August 26, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1583-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in physical medicine and rehabilitation. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 35 year-old male who sustained a work related injury on ___. The patient reported that while at work he was carrying heavy boxes of computer paper when he experienced a pulling sensation in his lower back. The patient was evaluated in the emergency room where he underwent X-Rays and was treated with analgesics and released. The patient then underwent an EMG, CT scan, myeolgram and discogram and was treated with conservative care. The patient underwent a left hemilaniotomy at L5-S1 discectomy, foraminotomy and nerve root decompression on 11/7/01. The patient is reported to have had an exacerbation of his work injury and is presently diagnosed with joint instability, lumosacral spine and disc disorder, lumbar spine.

Requested Services
Orthotrac Vest.

Decision
The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 35 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that the patient underwent a left hemilanimotomy at L5-S1 discectomy, foraminotomy and nerve root decompression on 11/7/01. The ___ physician reviewer indicated that the patient has experienced an exacerbation of his work injury. The ___ physician reviewer noted that the current diagnoses for this patient include joint instability and lumbosacral spine and disc disorder.

The ___ physician reviewer indicated that the patient has been prescribed an Orthotrac vest for treatment of his condition. The ___ physician reviewer explained that provided in the case file was a study involving the Orthotrac vest and disc pressure in cadavers. The ___ physician reviewer also explained that this study does not translate into functional outcome in patients. The ___ physician reviewer indicated that there is no controlled, randomized literature supporting the clinical efficacy of this device. The ___ physician reviewer explained that there is no strong medical evidence documenting the clinical efficacy of the Orthotrac Vest. Therefore, the ___ physician consultant concluded that the requested Orthotrac Vest is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 26th day of August 2003.